Nursing Facility Direct Care Add-on
Compliance Schedules, SFY 2006
Instructions

The Division of Health Care Finance and Policy (DHCFP) will use the compliance schedules in order to determine whether facilities have met the spending requirements specified in 114.2 CMR 6.06(1).

All data submitted on this form is subject to audit by the Division of Health Care Finance and Policy (DHCFP).

Data must be reported using the accrual basis.

Buyer/Seller Arrangements: A provider that purchased a facility during or after the base period remains responsible for ensuring that the direct care add-on was used in compliance with the Division's regulations. If the purchase occurred after May 31, 2003, the provider must use data from the seller in its calculation. If the sale was during the base period or rate periods, the data must be summed for the two providers.

New or Closed Facilities: Providers that closed or entered receivership during the rate period are still obligated to fulfill the requirements of the direct care add-on and complete these schedules. New facilities must complete the forms as instructed and indicate the open date of the facility.

Facilities with Residential Care Beds: The instructions require facilities to exclude data associated with residential care beds (also called "level IV beds"). In some cases, the results of the Division's compliance tests may be skewed as a result of this exclusion. Therefore, the Division may require facilities with these beds to supply additional information in order to adjust for this variance.

Schedule A: Data Summary

Schedule A collects data elements needed to determine compliance. Compliance calculations are completed on schedules B, C, D.

Facilities must fill out data for two periods: the base period (column 1), which is the period prior to the effective date of the add-ons, and the rate period (column 2), which is the period during which facilities received the add-on revenue. Note that the month of June is excluded in the first period.

Part A. Statistical Data

1. Direct care rate add-on per day. This is the "Direct Care Add-on" per diem amount specified in the facility's certified rate calculation received from the DHCFP. If the facility's rate changed during the rate period, the facility must report the weighted average direct care add-on amount on line 1, weighted by the number of Medicaid days in each period.
2. CNA pass through rate add-on per day. This is the "CNA Pass Through Add-on" per diem amount specific in the facility's certified rate calculation received from the DHCFP. As noted above, the facility should report the weighted average rate if the facility had different add-on amounts during the rate period.

3. Medicaid patient days. The total amount of Massachusetts Medicaid nursing facility patient days provided by the facility. Medicaid days includes Massachusetts Commission for the Blind days and Medicaid reserved days (hold days). Medicaid days also includes 95% of hospice days for which Massachusetts Medicaid is the primary payer. This does not include MA Medicaid Managed care days, days provided to residential care level patients ("level IV" days), or non-Massachusetts Medicaid days.
4. Total patient days. The total amount of nursing patient days provided by the facility. This includes Medicaid reserved days (hold days.) It does not include days provided to residential care level patients ("level IV" days).
5. Mean number of beds. The number of licensed operating beds, excluding residential care (level IV) beds. If the facility had changes in bed licensure during the base or rate periods, the facility must report the weighted average number of beds. The weighted average number of beds is ((total beds * days in effect) + (total beds * days in effect)…) / (total days in period).
6. Average management minutes. The number of reported management minutes on the facility's Medicaid Management Minute Questionnaire (MMQ) forms for the rate and base period. This data is reported to MassHealth quarterly. Minutes reported for purposes of DCA compliance should be based on un-audited data. For the base period, include the first two quarters of calendar year 2003, even though the base period ends on May 31 (i.e. include June in the minutes).
7. Total Registered Nurse hours. The number of paid hours for Registered Nurses. Includes hours for all staff, including staff from temporary nursing pools registered with the Department of Public Health. Includes overtime hours and other paid leave hours. Does not include hours for staff development, quality assurance, MMQ, or MDS.
8. Total Licensed Practical Nurse hours. The number of paid hours for Licensed Practical Nurses. Includes hours for all staff, including staff from temporary nursing pools registered with the Department of Public Health. Includes overtime hours and other paid leave hours.
9. Total Certified Nursing Assistant hours. The number of paid hours for Certified Nursing Assistants. Includes hours for all staff, including staff from temporary nursing pools registered with the Department of Public Health. Includes overtime hours and other paid leave hours. When reporting data for account 6051.1, facilities should include only hours for Certified Nursing Assistants or Nursing Assistants enrolled in the DPH CNA training programs. Hours for bed makers, feeding assistants, and therapy assistants should not be reported on this line.
10. Total Director of Nurses hours. The number of paid hours for the Director of Nurses. Includes overtime hours and other paid leave hours.
11. Total Direct care hours. The sum of lines 7, 8, 9, and 10.

Part B. Expense Data

Facilities must report the expenses specified on lines 12 to 29. The account numbers noted indicate the corresponding account on the HCF-1. Only amounts that would be claimed as allowable expenses on the HCF-1 should be reported. Expenses that are not related to the provision of nursing facility care and which would normally be reported as "self-disallowed" expenses on the HCF-1 should not be reported on Schedule A.

Note that the salary expenses include all salaries, including bonuses, shift differential pay, and overtime pay. Amounts claimed for purchased service (lines 24 – 26) must be for services provided by DPH-registered nursing pools or the facility's per diem staff.

When reporting data for account 6051.1, facilities should include only expenses for Certified Nursing Assistants or Nursing Assistants enrolled in the DPH CNA training program. Expenses for bed makers, feeding assistants, and therapy assistants should not be reported on this line. Nor should expenses for staff development, quality assurance, MMQ, or MDS be included.

Line 30 excludes the amount of revenue received from the CNA pass-through add-on during the base period.

Line 30a excludes the amount of one-time bonuses (and associated employer payroll taxes) paid to direct care workers before Dec. 15, 2005 to avoid penalties incurred by non-complying facilities in SFY 2005, as allowed by Administrative Bulletin 05-07. This amount may not be credited toward compliance in SFY 2006.

Line 31 excludes any recoverable income reported in accounts 3192.0 or 3195.0 in the HCF-1 report.

Schedule B: Compliance Tests 1, 2, 3

Schedule B provides the calculations for test 1/nursing costs in excess of the median, test 2/increasing wages & benefits, and test 3/increasing staff-to-patient ratio as specified in 114.2 CMR 6.06(1). The sources for these figures are noted in parentheses next to the description. Note that lines 3 and 10 are constant values and cannot be changed.

Collective Bargaining Agreements: Facilities must document that increased wages and benefits are over and above the amounts previously negotiated in a collective bargaining agreement. If the facility had a collective bargaining agreement in place on or before June 30, 2003, it must determine the amounts attributable to the increases required under that agreement. The gross amount of the increase must be reported on line 14. Do not report anything in the base period column.

Example: Facility A and a union entered into a collective bargaining agreement with their CNA staff. This contract went into effect on April 1, 2003. As part of this contract, the facility agreed to pay CNAs a 2% increase on April 1, 2004. The 2% increase that went into effect on April 1, 2004 cannot count toward compliance. Therefore, the facility must calculate the amount attributable to the increase and report in on line 14. To calculate the increase, multiply the per hour increase by the number of hours for the period that the increase was effective (in the example, this would be April 1, 2004 – June 30, 2004).

Base Period Rate Reduction Adjustment: As outlined in SFY04 Administrative Bulletin 04-06, the Division will increase the facility's base period expense to account for the operating rate reduction that was in place for March 1, 2003 to May 31, 2003. The amount of the adjustment will be $3.72 times 3/5 of the facility's base period Medicaid days.

Schedule C: Improved recruitment and retention

Schedule C provides calculations for test 4/improving facility's recruitment and retention. Facilities may choose to submit either Turnover Rate or Vacancy Rate information.

1. Average Number of Direct Care Workers. The average number of direct care workers (RN, LPN, CNA, DON) employed at the facility in the base and rate periods. To calculate the average, divide the sum of the number of direct care workers from all

months in each period employed at the facility by the total number of months in each period.

2. Number of Direct Care Workers Replaced. The total number of direct care workers that replaced workers reported in line 1 in the base and rate periods. Do not include vacant positions.
3. Turnover Rate. Divide line 2 by line 1.
4. Average Number of FTE Direct Care Positions. The average number of Full-Time Equivalents (FTEs) during each period. To calculate the total number of FTEs, divide the total annual paid hours (including overtime, vacation, sick, personal and holiday leave) for direct care employees by 2080 hours. To calculate the average number of FTEs, divide the total number of FTEs by the total number of months in each period.
5. Average Number of Unfilled FTE Direct Care Positions. The average number of vacant FTE positions during each period. To calculate the average, divide the sum of the number of vacant FTEs from all months in each period by the total number of months in each period.
6. Vacancy Rate. Line 5 divided by line 4.
7. Recruitment and Retention Spending. If the difference between the rate and base periods is less than zero, enter "0."Facilities must document the amounts spent on recruitment and retention efforts specifically related to direct care employees. Amounts claimed on this schedule must not include amounts previously claimed on schedule A. Facilities must provide a description of the amounts claimed and reference the HCF-1 accounts related to the claimed expenses. In addition, the facility must include a narrative explaining how these expenses demonstrably improved recruitment and retention efforts.

Facilities must attach a summary of claimed expenses, referencing the related HCF-1 account, and provide a narrative explaining how the claimed expenses demonstrably improved recruitment and retention.

Calculation of Recovery Amount

Each test calculates an amount that may be credited toward compliance. However, the same spending is measured in tests 1 /nursing costs in excess of the median and in test 2/increasing wages & benefits and in 3/increasing staff-to-patient ratio. There is no overlap of expenses in test 4/improved recruitment and retention. Therefore, the final compliance is determined as the higher of:

- The sum of test 1/nursing costs in excess of the median & test 4/improved recruitment and retention; OR
- The sum of test 2/increasing wages & benefits, test 3/increasing staff-to-patient ratio & test 4/improved recruitment and retention.